DEPARTMENT OF HUMAN SERVICES

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 260E.01, paragraph (a), "The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment."

Report Number: 202306930

Date Issued: October 31, 2023

Name and Address of Facility Investigated:

Sandcastle Child Care Center I
486 View St
Saint Paul, MN 55102

Disposition: Maltreatment determined as to neglect of an alleged victim by a staff person.

License Number and Program Type:

802189-CCC (Child Care Center)

Investigator(s):

Anna Parkin
Minnesota Department of Human Services
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
anna.parkin@state.mn.us
651-431-6225

Suspected Maltreatment Reported:

It was reported that a staff person (SP) lost his/her vape pen at the facility and an alleged victim (AV) found it and inhaled nicotine.

Date of Incident(s): August 11, 2023

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2):

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on August 25, 2023; from documentation at the facility and photographs provided by the AV's family member; and through three interviews conducted with a supervisory staff person (P), a facility staff person (SP), and the AV's family member (FM).

According to the AV's enrollment information, the AV was four years old and enrolled in the preschool room at the time of the incident.

The facility had a main hallway with a front door that family members used to access the facility. The preschool room was off the hallway and at the end of the hallway were sets of stairs. The stairs going down led to another hallway where there were cubbies that children stored their personal items. There was also a staff office that had lockers for staff persons to store their bags and personal items in while at the facility.

The FM stated that on August 11, 2023, s/he went to the facility and picked up the AV. The AV got a few items from his/her cubby and they walked out to the FM's vehicle. After the AV got inside the vehicle, the FM saw the AV put something up to his/her mouth, inhale and then coughed, and smoke came out of the item. The FM took the item from the AV and noticed it was a vape pen. The FM asked the AV where s/he got the vape pen from and because of the AV's limited verbal communication, the FM thought the AV said from inside the building. The AV did not experience any side effects afterwards. Since this occurred later on a Friday, the FM told the P the following Monday, August 14, 2023.

Photographs provided by the FM showed a white and black vape pen and "LOON" and "MAXX" written on it.

According to *theloonmn.com*, the LOON MAXX pen was a disposable vape pen that contained approximately 60 milligrams of nicotine salt inside the pen.

According to the Center of Disease Control and Prevention's website, vape pens contained nicotine, which was an "addictive drug" that was possibly harmful to the development of children's brains.

The SP provided the following information:

- On August 11, 2023, at the end of the SP's workday, s/he finished some work tasks around the main area of the facility. The SP kept his/her personal bag inside a locker near the children's lockers because it did not fit inside the staff lockers. The SP took a vape pen and a cell phone out of his/her personal bag and put them in his/her pocket. The SP realized s/he was missing an item from the work tasks, so s/he went downstairs to look for it. When the SP returned to the lockers, s/he realized that the vape pen was missing from his/her pocket. The SP said there was nicotine still inside the pen.

- The SP retraced his/her steps including on the stairs and did not see the vape pen. The SP then told between two and five other staff persons that s/he had lost his/her vape pen and they said they would keep an eye out for it. The SP did not tell the P about the lost vape pen because it was the end of the day and the P was no longer at the facility.

- On August 14, 2023, the SP returned to the facility and worked. At approximately 1 p.m., the P brought the SP into the P's office and told the SP about the AV and the vape pen. The SP felt "horrible."

According to the AV's *Weekly Sign In/Sign Out Sheet*, the AV was signed out at 5:30 p.m. According to the SP's

Time Card, the SP signed out at 5:53 p.m.

On August 14, 2023, the FM told the P about the incident with the AV. The P had heard through the "rumor mill" that the SP lost his/her vape pen, so the P spoke to the SP who said it was his/her vape pen and the SP was "horrified" and worried about the AV.

According to the facility's *Personal Property* policy, the facility provided lockers for staff persons to store personal items during the workday. All staff persons were required to store their personal items in their assigned locker.

According to the facility's *Risk Reduction Plan*, staff persons personal items were stored in lockers inside the facility office.

Facility documentation showed that the SP and other staff persons interviewed received training on the facility's *Personal Property* policy, *Risk Reduction Plan*, and the Reporting of Maltreatment of Minor's Act prior to the incident.

Relevant Rules and Statutes:

Minnesota Rules part 9503.0140, subpart 17, stated that sharp objects, medicines, plastic bags, and poisonous plants and chemicals, including household supplies, were stored out of the reach of children.

Conclusion:

A. Maltreatment:

Information was consistent that on August 11, 2023, the AV found a vape pen at the facility which was a violation of Minnesota Rules part 9503.0140, subpart 17, and inhaled it so that smoke came out of it.

The SP stated that s/he stored her bag in a locker near the children's locker which was a violation of the facility's policy on where staff were to store their bags. Although the SP did not instead to drop his/her vape pen while inside the facility, given that the SP was not to use the lockers near the children's and was in an area that children accessed when s/he took the vape pen out of his/her bag and put it in his/her pocket, that once the SP realized s/he lost the vape pen s/he did not notify any supervisory staff person and remained at the facility for 23 minutes after the AV had left the facility, and that the AV obtained and inhaled the vape pen, there was a preponderance of the evidence that there was a failure to supply the AV with necessary care and a failure protect the AV from conditions or actions that seriously endangered the AV's physical or mental health when reasonable able to do so.

It was determined that neglect occurred (Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

> When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:
>
> (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;
>
> (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
>
> (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP was trained on the facility's *Personal Property* policy, *Risk Reduction Plan*, and the Reporting of Maltreatment of Minor's Act prior to the incident. The SP was responsible for maltreatment of the AV.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of

> internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident for which the AV did not sustain an injury that required the care of a physician.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (c) all investigative data maintained in this report will be kept by the Department of Human Services for at least ten years after the date of the final entry in the report.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed. All staff persons received additional training on storage of personal items while at the facility.

Action Taken by Department of Human Services, Office of Inspector General:

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

On October 31, 2023, the facility was issued a Correction Order for the violation outlined in this report.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.